- Regular employees on an approved leave of absence (other than a military leave) and their enrolled dependents;
- Former regular employees who retire with a service or disability pension and their enrolled dependents;
- Former regular employees who are LTD-eligible and not eligible for a disability or service pension and their enrolled dependents;
- Surviving spouses of deceased employees/ retirees and their enrolled dependents;
- Former regular employees on Technological Displacement or layoff with extended medical coverage and their enrolled dependents;
- COBRA-covered individuals and their enrolled dependents.

Payment Allowance (PA). Limits established for non-PPO payments in each PPO area based on the negotiated fees charged to BellSouth by the PPO providers (e.g., hospitals and physicians) within that area. Amounts over the payment allowance are not covered by MAP and do not go toward the maximum out-of-pocket limit.

Pre-Existing Condition. See page 23.

Preferred Provider Organization (PPO). A hospital, physician or pharmacy that contracts with BellSouth to provide medical services to BellSouth participants at contracted fees.

PPO Area. A geographic area that contains a network of hospitals and/or physicians who have agreed to provide medical services to BellSouth participants for contracted fees. You live in a PPO area if your residence zip code is within 25 aerial miles of any PPO hospital. QCP can tell you if you live in a PPO area.

If you live in a PPO area and Medicare is not your primary plan, you are subject to MAP's PPO provisions for obtaining maximum plan payments, whether or not MAP is your primary plan.

Private Duty Nursing. Professional services provided by a registered nurse (RN) or a licensed practical nurse (LPN) are covered by the plan when these services require the special knowledge and skill of a trained professional nurse. Private duty nursing care requires precertification from QCP. Custodial/routine patient care or care that is provided by a non-professional individual is not covered under MAP.

Provider of Treatment. An individual who is licensed to prescribe and administer drugs or to perform surgery. Under MAP, this includes the following: Physicians, Surgeons, Chiropractors, Dentists, and Podiatrists who practice within the scope of their licenses. (Emergency medical care related to an accidental injury or sudden and serious illness must be provided by a medical doctor or surgeon, or dentist to qualify for reimbursement under MAP.)

"Physician" also means an individual who possesses a Doctorate degree (Ph.D, Psy.D or Ed.D) and who is licensed as a clinical psychologist and provides psychological services in connection with the diagnosis or treatment of a mental/nervous condition. To be eligible for reimbursement under MAP, these inpatient services must be precertified by QCP. Services provided by a social worker or counselor are not covered under MAP.

Quality Care Program (QCP). A feature of MAP designed to assist you in your selection of appropriate medical care and the avoidance of unnecessary medical expense. QCP is administered by United HealthCare, Inc.

QCP Penalty. If a participant fails to follow the QCP process or fails to follow the QCP recommendations, MAP payments are reduced by $250 for each failure to comply. The QCP penalty does not apply toward the MAP deductible or the out-of-pocket limit.

Reasonable And Customary (R&C). The fair and reasonable value of a medical procedure or service based on historical data developed from the following criteria:

A charge is "reasonable and customary" when:
• The fee is that which an individual physician or provider of medical service most frequently charges to the majority of patients for a similar service or medical procedure and which falls within the range of usual fees charged for that service by physicians or other medical providers with similar training and experience for the performance of similar services or medical procedures within the same locality, or

• Blue Cross and Blue Shield of Alabama determines if the fees are justified because of special circumstances, or medical complications requiring additional time, skill and experience in connection with a particular service or procedure.

Reasonable and customary charges for physicians and other covered medical services, for other than services provided by hospitals, will be determined and maintained by Blue Cross and Blue Shield of Alabama.

Retired Employee/Retiree. A former employee who was granted a service or disability pension by the company pursuant to a BellSouth Corporation Pension Plan. (A former employee who is eligible for or receives a deferred vested pension will not be considered a retired employee.)

Review. A request for review of any denied claim (either in whole or in part) or other disputed matter. You, your dependent, or a duly authorized person must submit the request for review within 180 days of receipt of notification of the denied benefits or other disputed matter.

Second Surgical Opinion. An independent physician's review of a patient's condition and recommended surgical treatment (see "Physician/Surgeon Care Benefits" on page 31).

Subrogation. Allows the claims administrator the right to recover benefits paid to a participant from a third party whose negligent or wrongful actions caused illness or injury to a participant. The claims administrator may assert this right directly against the third party or against any recovery that a participant has received from the third party.

For example, if you are injured in an automobile accident and the other driver is at fault, MAP will provide benefits for covered services related to the accident. However, the claims administrator has the right to recover any MAP payment amounts from the third party (e.g., automobile insurance).

ATTACHMENT 5

THE BELLSOUTH DENTAL ASSISTANCE PLAN

SUMMARY PLAN DESCRIPTION

REVISED JANUARY 1, 1993

Dental Assistance Plan

Table of Contents

Dental Assistance Plan

Introduction

A good smile and strong teeth are more than cosmetic assets—they're an important part of good health. The BellSouth Dental Assistance Plan (DAP) encourages employees to have regular preventive dental care and helps pay for dental care for you and each of your eligible dependents.

If you are a regular full-time employee with six months of service, your company will pay the entire cost for the Dental Assistance Plan for you and your eligible dependents. If you are a regular part-time employee with six months of net credited service, you may choose to participate in the plan, and your company will contribute at least part of your premium amount based on your date of hire.

The plan pays 100 percent of reasonable and customary charges for some covered preventive and diagnostic services. For other covered dental services, the plan pays according to a schedule. You pay a $25 deductible per covered person once each calendar year, unless one preventive treatment has been obtained within 12 months prior to the date of the treatment. You have a choice of dentists, and a predetermination of benefits option lets you and the dentist know in advance how much the plan will pay.

The plan covers only certain dental services and procedures. The most common exclusions are listed in this summary plan description.

Your Dental Assistance Plan coverage stops at the end of the month you leave your company, although you may have options for continuing coverage. If you retire on a service or disability pension, you and your eligible dependents will continue to be eligible for coverage. However, if you retired on or after Jan. 1, 1988, you will have to pay for any dependent (other than your spouse) added to your contract after retirement.

Effective Jan. 1, 1993, if you retired on or after Jan. 1, 1992, the cost of coverage for you, your spouse and other dependents will be paid by the company only up to the 1990 actual cost level. The schedules included in this summary plan description were effective on Jan. 1, 1993.

DAP is classified under the definitions of the Employee Retirement Income Security Act of 1974 (ERISA) as a welfare plan, and its original effective date was Jan. 1, 1983. Key features of the plan are explained on the following pages.

This summary plan description provides only a summary of the Dental Assistance Plan to answer some of the questions you may have about the plan. The summary plan description will be updated periodically to describe changes in the plan. There could be a delay between the time a change becomes effective and the date you receive a description of the change. Contact the plan administrator if you have questions about the plan's current provisions and benefits.

Please read this summary plan description carefully and keep it handy for ready reference.

Eligibility

For Employee or Retiree

If you are a regular full-time or part-time employee of a participating company, you are eligible for coverage under this plan on the day you attain six months of net credited service.

If you are a retired employee on a service or disability pension, you are eligible for coverage under this plan.

Regular full-time employees are covered automatically by the plan on the date they reach six months of net credited service. When regular part-time employees earn six months of net credited service, they must enroll for coverage under the plan.

For Spouse and Children

Your dependents will be covered by the plan on the same day your coverage becomes effective, provided you have enrolled them and provided the company pays the full cost of your coverage. If you enroll them later, their coverage will be effective on the date they meet eligibility requirements. If you enroll dependents after you retire, your dependents' coverage will be effective on the first day of the month after you enroll them.

Dependents include:

- your spouse;
- your unmarried children living with you, who may be covered until the end of the year in which they reach age 19 or, if they are full-time students, until the end of the year in which they reach age 23; and
- your unmarried child who is physically or mentally handicapped and is fully dependent on you for support.

Children include your natural children, legally adopted children, stepchildren or children for whom your spouse or you have been granted by a court a permanent legal guardianship and who live with you.

In cases where a legal relationship other than a permanent legal guardianship has been granted, in order for a child to be eligible for DAP coverage, all of the following criteria must be satisfied:

- The adult granted the relationship is a DAP participant.
- A court has ordered or approved the relationship, which:
  - is intended to remain in effect until such time that the child reaches majority.
  - imposes all of the legal obligations and rights on the adult that would exist in a normal parent/child relationship, including, but not limited to, full-time responsibility for housing, feeding, educating, clothing and disciplining the child.
- The relationship described above must have existed for a period of at least 12 months prior to a request for DAP coverage and must be verified through the presentation of the legal documents and court order that established the relationship.

If Both Parents Work for BellSouth

If you and your spouse both work for the same BellSouth company, one of you may waive coverage as an employee and be covered as a dependent under the other's coverage. If you and your spouse are employees of different BellSouth companies, each of you is covered

only as an employee. You should enroll eligible children for coverage by the parent whose birthday comes first in a calendar year.

No person can be covered as both an employee and a dependent under this plan, or as a dependent of more than one employee.

Eligibility for or participation in the plan does not constitute a guarantee of employment, nor does it interfere with the company's right to terminate employment.

Benefits

Coverage

The Dental Assistance Plan pays a maximum of $1,210 in benefits in a calendar year for you and $1,210 in a calendar year for each eligible dependent. There are also lifetime maximums for orthodontics and temporomandibular joint (TMJ) dysfunction.

The plan pays 100 percent of reasonable and customary charges for certain preventive and diagnostic care, called "Type A" services. Reasonable and customary charges are the actual fees charged by a dentist for a service rendered or a supply furnished. Provident Life and Accident Insurance Company, the claims administrator, determines what amount of a fee is reasonable. In making that judgment, Provident considers the following:

- The usual fee which the individual dentist most frequently charges the majority of patients for a service rendered or supply furnished;
- The prevailing range of fees charged in the same area by dentists of similar training and experience for the service rendered or supply furnished; and
- Unusual circumstances or complications requiring additional time, skill and experience in connection with particular dental services or procedures.

For other kinds of care, called "Type B" services, the plan pays according to a schedule (see Appendix II). Dollar amounts in the schedule are the maximum amount the plan will pay for a particular procedure. Before Type B benefits can be paid, you pay the first $25 of the scheduled allowances for you and each eligible dependent. A family limit applies after the deductible has been paid by three covered family members during a 12-month period. When this happens, the deductible for your entire family has been satisfied for that year.

The $25 deductible is waived when one preventive treatment is done within 12 months prior to the date you incur Type B services. This waiver applies separately to each covered person once each calendar year. Preventive treatment means routine cleaning and scaling of teeth, application of sealants for children under age 13 and fluoride treatments that qualify as Type A services.

In addition, the $25 deductible will be waived for participants who have complete (upper and lower) dentures.

Type A Services

Type A services, for which the plan pays 100 percent of the reasonable and customary charges, are:

- Routine oral examinations, but not more than two examinations in a calendar year. These exams are for diagnosing your oral health and determining what dental care you need.
- Prophylaxis (cleaning and scaling your teeth), but not more than twice in a calendar year,

when performed by a dentist or a dental hygienist.

• Fluoride treatments, excluding prophylaxis, when performed by a dentist or dental hygienist, including:

- Topical (local) application of sodium fluoride, but not more than four treatments in a calendar year, or
- Topical application of stannous fluoride, but not more than one treatment in a calendar year, or
- Topical application of acid fluoride phosphate, but not more than one treatment in a calendar year.

• Space maintainers (for dependent children under age 19 only), including installation of fixed or removable appliances designed only to maintain existing space created by the premature loss of teeth.

• Dental X-rays or radiographs, including:

- Full-mouth panorex X-rays, but not more than once in five consecutive calendar years;
- Supplementary bitewing X-rays, but not more than twice in a calendar year; and
- Any dental X-ray required to diagnose a specific condition that needs treatment, except X-rays in conjunction with orthodontia and TMJ.

NOTE: X-rays must be furnished to Provident in order to determine appropriate payment levels for impacted wisdom teeth extractions, gold restorations, crowns, dentures and bridgework.

Type B Services

Type B services, for which the plan pays according to a schedule listed in Appendix II of this summary plan description, are:

• Restorations, including fillings, inlays, onlays and crowns: treatment necessary to restore the structure of a tooth or teeth which have major decay or fracture. Inlays, onlays and crowns are covered only when a less costly restoration would not restore the teeth. (See the section, "Alternate Procedures.")

• Oral surgery: surgical procedures in and about the mouth.

• Endodontics, such as root canal work: procedures used for the prevention and treatment of diseases of the dental pulp (or root), excluding sedative bases or liners and implants.

• Periodontics: non-surgical and surgical procedures for treatment of the supporting area around the teeth.

• Prosthodontics: services to replace one or more teeth except third molars (wisdom teeth), extracted while the patient is covered under the plan. This includes:

- Initial installation of fixed bridge work, including inlays and crowns to form supports (abutments).
- Initial installation of removable partial or full dentures, including adjustments during the six-month period after they are installed.
- Adding teeth to an existing removable partial denture or to bridge work because of additional extractions.
- Installing a permanent full denture that replaces the teeth and is installed within 12 months of a temporary denture.
- Replacing an existing removable partial denture, full denture or fixed bridge work, with a prosthesis of the same kind, provided the existing denture or bridge is at least five years old and cannot be made serviceable. The five-year limitation is waived if additional extractions require the replacement.
- Repairing or re-cementing inlays,

crowns, bridge work or dentures, or re-lining of dentures.

• Orthodontics: Services for the prevention and correction of malocclusion of teeth (crooked teeth).

- Effective Jan. 1, 1993, the maximum lifetime benefit payable for orthodontia is $1,100 for each covered person age 20 or over, or $1,452 for each covered person under age 20. This maximum is in addition to and separate and distinct from the plan's $1,210 per calendar-year maximum for regular dental benefits.
- If you are under age 20 and you reached the $1,320 maximum lifetime benefit payable for orthodontia prior to Jan. 1, 1993, you will be eligible for the increased maximum lifetime benefit only if you are still receiving active orthodontic treatment. The bands must still be in place.

• Oral splints for non-surgical treatment of temporomandibular joint dysfunction (TMJ).

- Effective Jan. 1, 1993, the annual benefit maximum for oral splints for each covered participant is $250 with a lifetime maximum of $1,000.

• General anesthesia, when medically necessary and administered in connection with oral surgery. However, anesthesia agents and local anesthesia are not covered expenses.

• Sealant coverage: one treatment per lifetime for participants age 13 and under. Benefits are limited to one application per tooth or per quadrant during the lifetime of the patient.

Alternate Procedures

There is often more than one way to treat a particular dental problem. For example, sometimes either a crown or a filling could be used to restore a tooth. Also, dentists make choices regarding materials to be used, such as choosing between precious metals and plastic for restorations.

If you and the dentist decide on the more costly treatment, you are responsible for charges beyond those for the less costly alternate treatment paid by Provident.

Provident will pay the lower schedule amount, provided the treatment meets acceptable dental standards. Whenever the alternate procedures provision is applied, Provident's dental consultant reviews the claim.

Predetermination of Benefits

Predetermination of benefits lets you know what services are covered and what payments may be made for treatment before the work is done.

If you or one of your covered family members expects to have dental expenses of more than $200, such as expenses for dentures or crowns or root canal therapy, you should ask your dentist to file for predetermination of benefits. This assures that both you and the dentist will know in advance how much of the dentist's charges the plan will pay. Most dentists are familiar with predetermination procedures.

Here's how it works:

The dentist informs Provident of the proposed course of treatment, itemizing services and charges on the claim form you provide.

Provident then determines the amount the plan will pay and tells you and the dentist of its payment decision. You and your dentist should discuss the result before the work is done.

Predetermination of benefits can help you avoid surprises. Remember that the plan has a maximum amount it will pay in a calendar year.

If you do not ask for predetermination of benefits, Provident will pay the claim based on whatever information it has available. Predetermination of benefits could save you money by allowing you to consider alternate procedures (see the section, "Alternate Procedures").

If your dentist submits a treatment plan for predetermination of benefits and then changes the plan, Provident will adjust its payments accordingly. If changes in the treatment plan are major, the dentist should submit a revised plan.

NOTE: As indicated on the claim form's instruction sheet, to receive determination of payment levels, the dentist must submit X-rays to Provident for all crowns, bridge work, gold restorations and impacted teeth extractions.

Coordination of Benefits (COB)

The growing number of dental plans and the increasing number of two-income families mean that many people are covered or have the opportunity to be covered under more than one group plan. If you or your spouse or your dependents are eligible for more than one group plan, payments from all the plans combined will not exceed 100 percent of the allowable expenses.

An allowable expense is any necessary, reasonable and customary charge for dental services or treatment covered in whole or in part under the Dental Assistance Plan. Any items contained in the list of exclusions of this Dental Assistance Plan will not be considered an allowable expense, even if they are covered under another plan.

When claims are made under this Dental Assistance Plan and you or your covered family member is also covered by another group plan, it must first be determined which plan has primary responsibility and which plan has secondary responsibility.

When the other plan has a coordination of benefits provision, here's how primary responsibility is determined:

This dental assistance plan employee is	**Other insurance**	**Dental expenses of**	**Who pays first**	**Who pays second**
Husband	Wife's employer	Husband	We do	They do
		Wife	They do	We do
		Child	*	*
Wife	Husband's employer	Husband	They do	We do
		Wife	We do	They do
		Child	*	*

*When this plan and another plan cover the same child as a dependent of different persons, called parents, primary coverage comes from the plan of the parent whose birthday falls earlier in a calendar year (the "birthday rule").

If both parents have the same birthday, the plan which covered the parent longer is primary and the plan which covered the other parent for a shorter period of time is secondary.

Some plans do not use the birthday rule as described above, but instead use a rule based on the gender of the parent. If, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

When the other plan does not have a coordination of benefits provision, that plan is always primary and will pay first.

When primary, this Dental Assistance Plan will provide its regular benefits. When secondary, it pays the difference, if any, up to covered billed charges or the schedule amount, whichever is less.

NOTE: There is no COB between DAP and BellSouth Enterprises' Flexible Benefit Plan. This means that DAP never provides secondary coverage when primary coverage is provided by one of these plans.

Examples of How the Plan Works

Here are three examples of how the plan can work for you and your family.

EXAMPLE 1:

Your spouse goes to the dentist for the first time since coverage became effective. The dentist examines and takes X-rays of the patient's teeth, charts present dental condition and takes a dental history. For all these Type A services, the dentist charges $50.

As a result of the exam, the dentist fills five teeth (10 surfaces) and charges $190 for these Type B services.

The plan pays 100 percent of charges for the Type A services—in this case $50, which is determined to be reasonable and customary. For the Type B services, the schedule allows $165. Assuming your spouse had not obtained Type A preventive treatment in the last 12 months, the $25 deductible applies. So the plan payment for Type B services is $140.

Here is a summary of the claim payment:

	Dentist's charge	***Plan pays***	***Employee pays***
Type A Services	*$ 50*	*$ 50*	*$ 0*
Type B Services	*190*	*140**	*50*
TOTAL	*$240*	*$190*	*$ 50*

**Schedule allowance of $165 minus deductible of $25 equals $140 benefit.*

The employee has now satisfied the calendar year $25 deductible for this dependent. All future claims during this calendar year for this dependent will be paid without a deductible.

EXAMPLE 2:

After a dentist's examination and X-rays reveal serious dental disease, you have three upper teeth extracted and replaced by a partial denture. The exam and X-rays are Type A services, while the extractions and denture are Type B services.

Assuming you had already satisfied the calendar year $25 deductible, here is a summary of the claim payment:

	Dentist's charge	*Plan pays*	*Employee pays*
Type A Services			
Exam & X-rays	*$ 40*	*$ 40*	*$ 0*
Type B Services			
Extractions	*90*	*74*	*16*
Denture	*525*	*407*	*118*
TOTAL	*$655*	*$521*	*$134*

NOTE: Because of the nature and complexity of the dental treatment required, predetermination of benefits was used. See the section "Predetermination of Benefits."

EXAMPLE 3:
Your 16-year-old child has a malocclusion, and needs corrective orthodontic treatment (braces) to remedy the condition. Orthodontic treatment is always a Type B expense.

Assuming your child has Type A preventive treatment on a regularly scheduled basis, the $25 deductible will be waived each calendar year.

The following is a summary of the claim payment:

Date of service	Service	Dentist's charge	Plan pays	Employee pays
January 1993	Preliminary study with X-rays, diagnostic casts and treatment plan.	$ 100	$ 96	$ 4
February 1993	First month of active treatment including appliances.	650	491	159
March 1993 through May 1994	Active treatment per month after first month at $75 per month.	1,050 75	854 11*	196 64
June 1994 through December 1994	Active treatment per month after first month at $75 per month.	450	0	450
TOTAL:		$2,325	$1,452	$873

*Patient reached the $1,452 lifetime orthodontic maximum.

Filing a Claim

When you or a covered member of your family plans to visit the dentist, be sure to fill out Part 1 of the claim form according to the instructions. The dentist will fill out Part 2. Claim forms are available by calling Provident at one of the toll-free numbers listed in the section "Help."

Part 1 of the form includes an authorization for the dentist to release necessary information to

Provident so it may process your claim. This authorization must be signed as described on the form. This part also authorizes Provident to pay the dentist directly for work performed for you and members of your family. You must sign the claim (as the employee) to certify the accuracy of the information given in Part 1.

The dentist must submit X-rays with the claim form whenever the treatment plan contains charges for extracting impacted teeth, gold restorations, crowns, dentures and bridge work. Provident will return the X-rays promptly.

File a claim when a course of treatment is complete. Make sure all lines are completed on the claim form to eliminate any delay in processing your claim.

The provider or participant must file the claim no later than 12 months from the date of the treatment. Claims received after one year from the date the expenses were incurred will not be covered or paid.

Payment of Benefits

Provident Life and Accident Insurance Company processes the claims for benefits provided by this plan under an administrative services agreement with BellSouth Corporation.

Claim Denial

If you have a question about Provident's decision on your claim, you should contact Provident's Dental Claim Unit. When discussing your claim, please refer to the explanation of payment, the claim form and other correspondence you may have received from Provident. Use the toll-free telephone number shown on your claim form to contact Provident.

If a claim for plan benefits is denied, in whole or in part, you or your dependent will receive written notification from the Provident Life and Accident Insurance Company. This written notification will include:

- The specific reason or reasons for the denial.
- Specific reference to pertinent plan provisions on which the denial is based.
- A description of any additional material or information necessary for you to perfect your claim, and an explanation of why you must supply such material or information.
- Appropriate information about the steps you or your dependent or a duly authorized representative must take if you wish to submit the claim for review.

If you do not hear from Provident within 90 days after it receives your claim, submitted according to the procedures in the section, "Filing a Claim," your claim is considered denied.

Cost

If you are a regular full-time employee, the company pays the full cost of coverage for you, your spouse and other dependents, beginning on the date you complete six months of service.

If you are a regular part-time employee who was hired or re-engaged (after a break in service) on or after Jan. 1, 1990, and who works less than 37.5 hours in a week, you will pay a portion of the cost of your coverage, based on the ratio of your weekly hours worked to a 37.5-hour work week.

For example, if you work 7.5 hours each day for three days a week (a total of 22.5 hours each week, or 60 percent of a 37.5-hour work week),

the company will pay 60 percent of the cost of your coverage, either individual, two-party or family. You will be required to pay the remaining 40 percent of the cost.

If you are a regular part-time employee who was hired after Dec. 31, 1980, and were on the payroll on Dec. 31, 1989, your weekly cost will be either the current rate for your work hours or the rate that was in effect between Dec. 31, 1980, and Dec. 31, 1989, whichever is less. However, you must remain continuously employed without any service breaks.

The rate in effect for part-time employees hired during the period from 1981 to 1989 are as follows:

If your weekly work sechedule is	**BellSouth pays**
Less than 16 hours	0%
16-24 hours	50%
Greater than 24 hours	100%

Exclusions

This plan does not cover charges for:

- Work done primarily for appearance or cosmetic purposes, including facings on crowns and bridges farther back than the second bicuspid.
- Work done while you were not covered under this plan, except as provided under an extension of benefits provision.
- Replacement of teeth removed before coverage is effective.
- Fees for services which are in excess of reasonable and customary charges.
- Appliances, restorations and procedures to alter vertical dimension and restore occlusion, including temporomandibular joint dysfunction or TMJ, except oral splints.
- Replacing lost or stolen appliances.
- Extra sets of dentures or other appliances.
- Work that is otherwise free of charge to patients.
- Work that is furnished or payable by the armed forces of any government.
- Services or supplies not necessary for proper dental care.
- Broken appointments.
- Completion of claim forms or filing of claims.
- Educational training programs, dietary instructions, or plaque control programs.
- Implantology (implants).
- Hospitalization for dental treatment, either in-patient or out-patient.
- Additional charges beyond those for a comparable less costly alternate treatment.
- Treatment resulting from declared or undeclared war, insurrection, participation in a riot, or service in the armed forces of any government.
- Work which is payable under Workers' Compensation or similar laws.
- Services covered by any other health plan of this company.
- Anesthesia, except general anesthesia, when medically necessary in connection with oral surgery.
- Drugs or their administration.
- Experimental procedures.
- Services received as a result of accidental injury to teeth. (Accidental injury expenses may be covered under the Medical Assistance Plan.)

All listed covered expenses are subject to amendments made to this summary plan description.

If You Leave the Company

Your coverage and coverage for all your dependents ends on the last day of the month in which you leave the company, die or fail to make a required payment while on an approved leave of absence or layoff.

Coverage of a dependent ends on the last day of the month in which the individual ceases to be an eligible dependent (turns 20, graduates from college, etc.).

For special coverage extension, see the section, "COBRA Benefits."

If you have eight or more years of service and terminate under the Career Alternative Plan (CAP), you may be eligible for up to 36 months of continued coverage at the company's expense.

The plan will not pay for services or supplies furnished after coverage terminates, even if Provident has predetermined the payments for a treatment plan submitted before you leave the company. But under the extension of benefits provision, the plan will pay the scheduled amounts for:

- A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the supporting (called "abutment") teeth while you were covered, and delivers and installs the device within two calendar months after coverage stops.
- A crown if the dentist prepared the tooth for the crown while you were covered by the plan, and installs the crown within two calendar months after coverage stops.
- Root canal therapy if the dentist opened the tooth while you were covered and completes the treatment within two calendar months after coverage stops.

Leave of Absence or Layoff

While you are on an approved leave of absence, other than for military service, you can continue your Dental Assistance Plan coverage by paying the full cost of the plan for yourself and your eligible dependents. If you decide not to pay the cost, your coverage stops at the end of the month you go on leave. Coverage resumes on the first of the month after you return to work.

If you are eligible for company-paid coverage and take a leave of absence for the care of a newborn child or for dependent care, the company pays the full cost of coverage for the first six months.

If you are laid off, you can continue your dental assistance coverage for 90 days by paying the full cost of the plan for yourself and your dependents. If you decide not to pay the cost, your coverage stops at the end of the month in which you are laid off. Coverage resumes on the first of the month after you return to work.

Retirement

If you retire from the company on a service or disability pension, the company currently intends to continue your coverage and coverage for your eligible dependents (who were covered prior to the date of your retirement) during your retirement through the last day of the month in which you die. However, the company reserves the right to change or modify coverage, including reduction, elimination of coverage, or requiring retirees to pay all or a greater portion of the cost of coverage, at its discretion.

NOTE: If you retire on or after Jan. 1, 1988, you may provide coverage for any eligible dependent other than your spouse added to your contract by paying the full premium rate for each additional dependent.

Competitor Rule and Benefit Forfeiture

If you retired on or after Jan. 1, 1991, you may forfeit your right and your dependents' right to certain post-retirement benefits if you provide services to or acquire an interest in a BellSouth competitor during the five years following retirement from BellSouth. **Please note that once such coverage is terminated, it will not be reinstated.**

Definition of a Competitor

A competitor of BellSouth or its affiliates is one who, in BellSouth's judgment, is engaged directly or through an affiliate in any line of business in which BellSouth or one or more of its affiliates is engaged, such as, but not limited to: the provision of telecommunications goods or services; the printing, publication, or provision of classified directories; the provision of cellular communications; and the provision of paging goods or services.

As set forth in the BellSouth Medical Assistance Plan, Dental Assistance Plan, Group Life Insurance Plan, and the Death Benefit provisions of the Pension Plan or the Management Pension Plan, a former employee will forfeit entitlement to post-retirement benefits under the foregoing plans if, during the five-year period following the employee's retirement:

• The employee acquires ownership of more than 5 percent of any class of stock of, or acquires beneficial ownership of, more than 5 percent of the earnings or profits of a competitor, or
• The employee becomes employed by, renders services to, or consults with a competitor, unless the employee's activities on behalf of the competitior make no use, directly or indirectly of:

- BellSouth proprietary or customer information, or
- Skills that the employee developed or used, or training provided to the employee during the last five years of the employee's employment by BellSouth or any of its affiliates.

During the five-year period over which the Forfeiture Provision is applicable, the business activities of BellSouth and its affiliates at the time that a former employee acquires an ownership interest in, or becomes employed by, changes assignments with, renders services to, or consults with another business entity will determine whether that entity is a competitor.

Health and welfare benefits are deemed terminated upon the date of occurrence of the forfeiture event, i.e., the date that more than 5 percent ownership interest in a competitor is acquired, or the date that employment with a competitor is begun. Upon learning of a forfeiture event, BellSouth reserves the right to seek the reimbursement of any benefits that were paid following the occurrence of that event.

Request for Benefit Forfeiture Ruling

An employee may file a "Request for Benefits Forfeiture Ruling" with the retiree benefit organization before acquiring an ownership or beneficial interest in another entity or before engaging in any post-retirement employment activity. On the basis of the information included in the request, the employee will receive a binding determination, based on the activity described in the request, as to whether the entity is a competitor, and if applicable, if the activity in question is deemed to be in competition with BellSouth.

Employees who disagree with the response that they receive to a Request for Benefits Forfeiture Ruling may request to have that response reviewed. In order to prevent a possible forfeiture, such a review should be indicated and completed before engaging in the activity at issue.

The addresses of the various company Employees' Benefit Committees are listed below:

- BellSouth Business Systems
- BellSouth Communications, Inc.
- BellSouth Communications Systems
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Telecommunications, Inc.
- BellSouth Financial Services Corporation

Room 18H62 Southern Bell Center
675 W. Peachtree Street, N.E.
Atlanta, Georgia 30375

- BellSouth Advertising & Publishing Corporation
- BellSouth Enterprises, Inc.
- BellSouth Information Systems, Inc.
- BellSouth International, Inc.
- BellSouth Mobility Inc
- BellSouth Resources, Inc.
- Sunlink Corporation
- Intelligent Media Services, Inc.
- Intelligent Messaging Services, Inc.

Room 5C08
1100 Peachtree Street, N.E.
Atlanta, Georgia 30309

Appeal of Benefit Forfeitures

Employees who have their benefits eligibility terminated under the Forfeiture Provision may, on their own behalf or through a representative, have that action reviewed by submitting a written appeal within 60 days of their receipt of the notification of termination of eligibility to the secretary of their company's Employees' Benefit Committee at the address shown previously.

If the appeal is denied, the employee will receive written notice of the Employees' Benefit Committee's decision, including the specific reasons for the decision and the procedures for appealing the decision, within 90 days of the date the committee received the appeal.

In some cases, the committee may need more than 90 days to make a decision. In such cases, the committee will notify the employee in writing within the initial 90-day period and explain why more time is needed. An additional 90 days may be taken to make the decision if the committee sends this notice. The extension notice will show the date by which the committee's decision will be sent. If the committee does not give its decision within the designated time span, the appeal is deemed to be denied.

An employee whose appeal to the Employees' Benefit Committee is denied, or deemed denied where no reply is received within 90 days, or if an extension was requested, within 180 days, may challenge such a denial by submitting a written appeal to the secretary of the BellSouth Corporation Employees' Benefit Claim Review Committee at the following address:

Room 1927
1155 Peachtree Street, N.E.
Atlanta, Georgia 30367-6000.

Such an appeal must be submitted in writing within 60 days after the receipt of the Employees' Benefit Committee's denial notification, or if no denial is received, within 60 days of the date that the original appeal was deemed to be

denied. The Employees' Benefit Claim Review Committee will conduct a review and issue a determination within 60 days after receipt of the appeal. In some cases, the Claim Review Committee may need more than 60 days to make a decision. In such cases, the Claim Review Committee will notify the employee in writing within the initial 60-day period and explain why more time is needed. The Employees' Benefit Claim Review Committee may then have 60 days more, or a total of 120 days, in which to make its decision.

The Employees' Benefit Claim Review Committee will issue a final written decision that will include specific reasons for the decision. If the Employees' Benefit Claim Review Committee does not issue its decision within the appropriate time span, the appeal is deemed to be denied.

In submitting an appeal either to the Employees' Benefit Committee or the Employees' Benefit Claim Review Committee, the employee is entitled to include a written statement of the issues and any other documents in support of the appeal. All material provided to either committee will be carefully considered in the determination.

BellSouth has delegated to the company Employees' Benefit Committees and the BellSouth Corporation Employees' Benefit Claim Review Committee the duty to administer the appeal of benefit eligibility terminations under the Forfeiture Provision. The company Employees' Benefit Committees and the BellSouth Employees' Benefit Claim Review Committee have the discretion and authority to interpret and to enforce the Forfeiture Provision, and their determinations and interpretations are final and conclusive.

As a participant in the various benefit plans subject to the Forfeiture Provision, you have further rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Those rights are described in detail in the summary plan descriptions issued for each affected plan.

Service or Disability Pension After Jan. 1, 1992

Employees retiring after Jan. 1, 1992, are subject to paying a portion of the cost of their retiree health care coverage. Beginning Jan. 1, 1993, and each year thereafter, your share of the cost for retiree coverage will be the excess of the capped amount (1990 actual cost level increased 11.4 percent) for two years in arrears from the current year.

For management employees, a premium will not be required until the costs exceed the capped amount (the 1990 actual cost level plus 11.4 percent). This is estimated to occur on Jan. 1, 1994.

For non-management employees, as a result of 1992 bargaining, a premium will not be required prior to Jan. 1, 1996. In addition, a Retiree Premium Offset Fund was established for non-management employees that will be applied toward the premium cost.

COBRA Benefits

On April 7, 1986, Congress enacted a federal law—the Consolidated Omnibus Budget Reconciliation Act (COBRA)—requiring that most employers who sponsor group health plans offer employees and their dependents the opportunity for temporary extension of health

coverage in certain situations where that coverage would otherwise end. This coverage, called COBRA coverage, is available at 102 percent of group rates. The Dental Assistance Plan is considered a group health plan.

The information in this section provides a summary of your rights and obligations under COBRA. You, your spouse and your other covered dependents should read this section carefully.

If you are an active, regular employee (or a regular employee on an approved leave of absence) covered by the BellSouth Dental Assistance Plan, you have a right to choose COBRA coverage for yourself and your covered dependents if you lose coverage because your employment has been terminated. This includes:
- termination because of retirement or
- a reduction in hours, but does not include termination for reasons of gross misconduct on your part.

If you are the spouse of an employee covered by the plan, you have the right to choose COBRA coverage for yourself and your covered dependents if your coverage ends for any of the following three events:
- the death of your spouse (for spouse of a retiree, death must occur within 18 months of retirement);
- termination of your spouse's employment for reasons other than gross misconduct, including retirement or a reduction in hours; or
- divorce from your spouse (for spouse of a retiree, divorce must occur within 18 months of retirement).

Your covered dependents have the right to elect COBRA coverage for themselves if coverage ends for any of the following four events:
- death of a covered employee or former employee (for dependent of a retiree, death must occur within 18 months of retirement);
- termination of the covered employee's employment for reasons other than gross misconduct, including retirement or a reduction in the covered employee's hours;
- divorce, or
- the dependent ceases to be a dependent under the provisions of the plan; for example, because of age or financial dependency (for dependent of a retiree, change in status must occur within 18 months of retirement).

Under the law, you or a family member has the responsibility to inform the Benefit Office within 60 days after losing coverage because of divorce or because a dependent has ceased to meet the criteria outlined in the section "Eligibility." The company has the responsibility to notify the appropriate Benefit Office of an employee's death or termination of employment.

When the Benefit Office is notified that one of these events has happened, it will notify you that you have the right to choose COBRA coverage. You have 60 days from the latter of the following two dates to inform the Benefit Office that you want COBRA coverage:
- The date you would lose company-paid coverage because of one of the events described above, or
- The date the COBRA election form is sent to you from the Benefit Office.

If you do not choose COBRA coverage, your coverage ends in accordance with the Dental Assistance Plan provisions.

If you choose COBRA coverage, the company is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated active employees. The law requires that you be afforded the opportunity to

maintain COBRA coverage for 36 months, unless you lost coverage because of a termination of employment, including retirement or a reduction in hours. In those cases, the required COBRA coverage period is 18 months. However, the 18-month period may be extended to a 29-month period if you are receiving Social Security disability benefits.

If you continue to receive benefits at company expense following one of the events that trigger COBRA coverage (i.e., you separate employment under the Career Alternative Plan), you may not want to begin paying the COBRA-required premium until your company-sponsored coverage ends.

Please note, however, that your COBRA eligibility period will run concurrently with the time period that you receive company-paid benefits. In such cases, therefore, you would be eligible for COBRA coverage only for the balance of the COBRA eligibility period that remained following the expiration of company-paid benefits.

The law also provides that your COBRA coverage may be cut short for any of the following reasons:

- The company no longer provides group dental coverage to any of its employees;
- The charge for your COBRA coverage is not paid on a timely basis; or
- You become covered as an employee or otherwise under another group plan.

You do not have to show that you are insurable to choose COBRA coverage. However, under the law, you will have to pay up to 102 percent of the group rate for your COBRA coverage during your 18-month or 36-month continuation coverage period. In addition, if you are receiving Social Security disability benefits, the cost of your COBRA coverage will be 150 percent of the group rate. At the appropriate time, the company will provide you with information on how to elect continued coverage under COBRA.

At the end of the COBRA coverage period, your coverage under the Dental Assistance Plan ends. There is no conversion allowed under the Dental Assistance Plan.

Plan Continuance

The company currently intends to continue the Dental Assistance Plan but reserves the right to amend or terminate it at any time, subject to any applicable collective bargaining agreements. No amendment or termination shall affect payment of benefits already received prior to plan amendment or termination.

The benefits described in this summary plan description reflect the provisions of the Dental Assistance Plan as outlined in current agreements, if any, between the "participating companies" and the various unions representing employees of those companies in collective bargaining units. Copies of these agreements are distributed or made available to employees covered by them.

Other Important Information

The name of this plan is the BellSouth Dental Assistance Plan. The plan is classified under the Employee Retirement Income Security Act of 1974 (ERISA) as a welfare plan. The group plan described in this summary plan description provides only dental coverage.

Plan Funding

BellSouth currently provides for the payment of plan benefits through one of two established trusts, one for management employees and the other, which is a negotiated trust, for non-management employees. These trusts fund active health benefits for employees and their covered dependents. The trusts also accept participant contributions for vision coverage. In addition, the participating companies make periodic contributions to the trusts to meet the plan's obligations. The trustee of both trusts is:

Nation's Bank
Master Trust - Southeast
7th Floor
600 Peachtree Street, N.E.
Atlanta, Georgia 30308

Contributions for coverage are made by the company and by employees when required.

Benefit payment checks that are not cashed within 90 days after the date of the check will be considered null and void and the benefit paid will be forfeited. Any forfeited benefit may be reconsidered by filing a claim for the forfeited amount within 12 months from the date of treatment and satisfactorily demonstrating entitlement to the payment.

Plan Administrator

The plan administrator is:

BellSouth Corporation
Room 7B09
1155 Peachtree Street, N.E.
Atlanta, Georgia 30367-6000
Telephone: (404) 249-2328.

BellSouth Corporation has delegated responsibility for handling plan administrative services for the employees of each company as follows:

- BellSouth Advertising & Publishing Corporation (non-management employees only)

  Assistant Secretary
  BellSouth Enterprises
  Employees' Benefit Committee
  59 Executive Park South, N.E.
  Atlanta, Georgia 30329
  Telephone: (404) 982-7027

- BellSouth Communications, Inc.
- BellSouth Financial Services Corp.
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Communications Systems
- BellSouth Business Systems
- BellSouth Telecommunications, Inc.

  ACTIVES:
  Secretary
  Employees' Benefit Committee
  Suite 1400
  3000 Riverchase Galleria
  Birmingham, Alabama 35244
  Telephone: 1-557-6179 (Local service provided by South Central Bell.)
  780-2029 (Local service provided by Southern Bell.)
  (205) 733-3001, call collect (Local service provided by any other company.)

  RETIREES:
  Operations Manager
  BellSouth Benefits Administration
  P.O. Box 54299
  Atlanta, Georgia 30308-0299
  Telephone: 1-557-6666 (Local service provided by South Central Bell.)
  780-2025 (Local service provided by Southern Bell.)
  1-800-842-1558
  (all others)

Plan Administration

BellSouth has delegated to Provident Life and Accident Insurance Company, Fountain Square, Chattanooga, Tennessee 37402, the duty to administer all claims for plan benefits for all participating companies. The Administrative Services Agreement between BellSouth Corporation and Provident governs the operation of the plan at all times. This agreement designates Provident as claims administrator.

Provident, with regard to administrative services delegated to it, has the sole and exclusive right and authority to determine benefits under the plan and to interpret the provisions of the plan. Provident's determinations and interpretations are final and conclusive.

Legal Service

Direct legal papers that deal with claim payments to Provident Life and Accident Insurance Company, Fountain Square, Chattanooga, Tennessee 37402.

Direct legal papers concerning the plan to the appropriate Benefit Committee secretary or assistant secretary listed in the section, "Plan Administrator."

Plan Records

The Dental Assistance Plan and all of its records are kept on a calendar year basis.

Plan Documents

This summary plan description is a summary of the Dental Assistance Plan and does not attempt to cover all the details. Specific details are contained in the Administrative Services Agreement between Provident Life and Accident Insurance Company and BellSouth Corporation, which legally governs the operation of the plan.

As a plan participant, you are entitled to examine, without charge, plan documents, including the Administrative Services Agreement, the annual report of plan operations, and other documents and reports that are maintained by the plan or filed with a federal agency. These documents are available for review during normal working hours at your Benefit Office. If you are unable to examine these documents there, write to the appropriate Benefit Committee secretary or assistant secretary, listed in the section, "Plan Administrator." Specify the documents you want to examine and at which company work location you wish to examine them. Copies of such documents will be made available for examination at that work location within 10 days of the date your request is received. Retired participants should write to the operations manager, listed under "Plan Administrator."

At any time, you may request copies of any plan documents by writing to the appropriate Benefit Committee secretary or assistant secretary listed under "Plan Administrator." A reasonable fee will be charged for copies of the documents requested.

Plan Identification Numbers

The plan is identified by the following numbers under Internal Revenue Service(IRS) rules:

#58-1533433	Employer identification number, assigned by IRS.
#505	Plan number, assigned by the company.

Appeal of Claim Denial

If a claim for benefits is denied, you, your dependent or a duly authorized person may appeal this denial or other action in writing, within 60 days after you receive notification of Provident's decision. If Provident does not send any notification, you may file your appeal within 60 days after the 90-day period discussed "Claim Denial." Send written requests for review of any denied claim or any other disputed matters directly to the Provident Life and Accident Insurance Company, Dental Claim Unit, Post Office Box 182558, Chattanooga, Tennessee 37422.

The person sending a request has the right to:
- Review pertinent plan documents. You may get these documents by following the procedures outlined in the section "Plan Documents."
- Send to Provident a written statement and any other documents in support of your claim for benefits or other matters under review.

Provident will provide you a written response to the appeal within 90 days after it is received. If Provident denies your claim again, you may have further rights under ERISA; see the section "Your Rights Under ERISA."

Help

If you need to file a claim or ask a question about the Dental Assistance Plan, write to Provident at the following address:

Provident Life and Accident
Insurance Company
P.O. Box 182558
Chattanooga, Tennessee 37422

or call one of the following toll-free numbers:

Outside Tennessee	1-800-251-6401
Tennessee	1-800-572-7343
Chattanooga	755-3100

Participating Companies

The Dental Assistance Plan is available to the following participating companies (referred to in this summary plan description as "the company" or "companies") who are eligible for coverage under this plan.
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Advertising & Publishing Corporation (retirees and non-management employees only)
- BellSouth Communications, Inc.
- BellSouth Financial Services Corporation
- BellSouth Telecommunications, Inc.
- BellSouth Communications Systems
- BellSouth Business Systems

The following companies participate for retirees only.
- BellSouth Enterprises, Inc.
- BellSouth Information Systems, Inc.
- BellSouth International, Inc.
- BellSouth Mobility Inc
- BellSouth Resources, Inc.
- Sunlink Corporation
- Intelligent Media Services, Inc.
- Intelligent Messaging Services, Inc.

This list of participating companies may change. Contact your Benefit Office if you have any questions about whether your employer is a participating company.

Your Rights Under ERISA

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) to safeguard your interests and those of your beneficiaries under your employee benefit plans. As ERISA requires, this section provides a statement of your rights and protections under this law.

ERISA does not require a company to provide benefits, but does set standards for any benefits a company wishes to offer—and it requires that you be given an opportunity to learn what these benefits are and your rights to them under the law.

It is your right to know as much as possible about your benefits. This summary plan description is one way to help keep you informed.

As a participant in the Dental Assistance Plan, you are entitled to certain rights and protections under ERISA.

- You may examine, without charge, at the plan administrator's office and at other specified locations, all plan documents, including contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor. This includes detailed annual reports and plan descriptions.
- You may obtain copies of all plan documents and other plan information by requesting them in writing from the plan administrator. The administrator may make a reasonable charge for the copies.
- You may receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of the summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in your interest and in the interest of other plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right under the plan to request a review and reconsideration of your claim.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to pay you up to $100 day until you receive the materials, unless they were not sent for reasons beyond the administrator's control.

If you have a claim for benefits which is denied or ignored, in whole or in part, after you have exhausted the plan's appeal program, you may file suit in a state or federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these expenses. If you lose, the court may order you to pay these costs and fees. For example, the court may order you to pay costs and fees if it finds your claim frivolous.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated